A broad-based coalition to preserve the integrity of Michigan's model No-Fault Insurance System

216 N. Chestnut Street, Lansing, MI 48933 (517) 882-1096
www.CPAN.us Facebook.com/ProtectNoFault

SUMMARY ANALYSIS OF HB 4612 - PROPOSED NO-FAULT LEGISLATION

By: George T. Sinas
Sinas Dramis Law Firm
CPAN General Counsel
April 24, 2013

On April 23, 2013, HB 4612 was introduced in the Michigan House of Representatives. The Bill imposes unprecedented dollar cap limitations on medical benefits and significantly restricts what treatment, services, and benefits are available to persons seriously injured in motor vehicle accidents. ***A number of the benefit restrictions contained in this Bill were contained in Proposal C, a referendum, which was resoundingly defeated by Michigan voters in 1994.*** The major features of this Bill are summarized below:

1. ***Eliminates Lifetime Care*** - The Bill eliminates the current lifetime medical and rehabilitation coverage available under §3107(1)(a) and replaces this with a lifetime benefit cap of $1 million. [§3107(1)(a) - pg. 32].

2. ***More Restrictive Benefit Eligibility*** - The eligibility standard for payment of PIP allowable expense benefits under §3107(1)(a) is severely restricted. Under current law, insurance companies must pay for *"all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation."* Under the new Bill, insurance companies are only required to pay *"all reasonable charges incurred for **medically appropriate** products, services and accommodations for an injured person's care, recovery or rehabilitation."* [§3107(1)(a) - pg. 32].* However, later in the draft Bill, the eligibility standard for the payment of allowable expense benefits is further limited in at least five (5) ways, all of which apply to any type of products, services, or

accommodations. These additional eligibility restrictions are as follows:

(a) The product, service, or accommodation must be *"medically appropriate and medically necessary"** and cannot be for *"experimental treatment or participation in research projects."* *[§3107(3)(F)(H) - pg. 35, 36];*

(b) The product, service, or accommodation must be *"reasonably likely to result in meaningful and measurable lasting improvement in the injured person's functional status."* *[§3107(3)(F) - pg. 35];*

(c) The product, service, or accommodation must not be for something that *"would have been needed or used by the injured person or a member of the injured person's household regardless of the loss occurrence."* [§3107(3)(F) - pg. 35];*

(d) The product, service, or accommodation must not be provided *"primarily for the convenience of the individual, the individual's caregiver or the health care provider."* [§3107(3)(L) - pg. 37];

(e) The product, service, or accommodation must be *"provided in the most appropriate location where the service may, for practical purposes, be safely and effectively provided."* [§3107(3)(M) - pg. 37].

3. ***Rehabilitation Benefits Limited*** - Rehabilitation coverages are limited in several ways in addition to the limitations set forth above. Specifically, rehabilitation coverages are limited as follows:

(a) The rehabilitation must be *"medically appropriate rehabilitation services that are reasonably likely to produce significant rehabilitation;"**

(b) The rehabilitation is limited to 52 weeks, which can be extended another 52 weeks if the rehabilitation is *"reasonably likely to produce significant rehabilitation."* The rehabilitation can be further extended beyond 104 weeks if *"it is reasonably likely that longer treatment may produce significant measurable improvement."* [§3107(3)(I) - pg. 36].*

4. ***Attendant Care*** - Attendant care benefits are severely limited in the following ways:

(a) In-home attendant care rendered by family or household members is limited to 56 hours a week (i.e., 8 hours per day) and capped at $15 per hour, regardless of the level of care provided or whether the family care provider is licensed or works for a licensed agency. [§3107C(1) - pg. 38];

(b) In-home attendant care provided by non-family or household members is limited to 16 hours per day, regardless of the patient's needs or the number of people required to render the care. If attendant care is needed 24 hours per day, it is only compensable if family or other household members render care 8 hours per day and an outside care provider renders care the other 16 hours per day. If more than 1 care provider is needed at the same time, payment is available for only 1 care provider. After 30 days of attendant care, there is a patient co-pay up to $200 per month. [§3107C(2)(3) - pg. 38, 39].

5. ***Home Modifications*** - Home modifications are significantly limited. The modifications must be those that are *"directly necessitated by and related to the injured person's injuries, if the accommodations are functionally necessary to meet the injured person's treatment, rehabilitation, maintenance, and daily living needs."* Moreover, the maximum lifetime benefit is $50,000. [§3107(3)(J) - pg. 36].*

6. ***Special Transportation Vehicles*** - Coverage for special transportation vehicles is limited in two (2) ways. The special transportation vehicle or modifications must be *"directly necessitated by and related to the injured person's injuries."* In addition, this transportation benefit is capped at $50,000 once every seven (7) years. [§3107(3)(K) - pg. 37].*

7. ***Medical Fee Schedules*** - The Bill creates a medical fee schedule system in two (2) ways:

(a) Providers may not charge no-fault insurers any more than what they customarily ***receive*** for like products, services, and accommodations in cases not involving PIP, not involving Medicare, or not involving Medicaid. However, the language in the Bill may be subject to a different interpretation which would limit the provider to the lowest amount received by that provider in any of those three scenarios. [§3157(1) - pg. 46].*

(b) If insurers request *"information to determine the appropriate reimbursement under this section and the information is unavailable or not provided or the information provided is not sufficient to determine the appropriate reimbursement,"* the insurer need only pay the provider in accordance with the workers' compensation fee schedule. [§3157(2)(3) - pg. 46, 47].*

This Bill further provides that *"a charge . . . is reasonable if the charge is in accordance with Section 3157."* [§3107(3)(e) - pg. 35].

8. ***Motorcycle Claims*** - Motorcyclists are only entitled to $250,000 of PIP coverage regardless of how or why the accident happened, which limitation apparently includes wage loss and replacement services. [§3107(3)(C) - pg. 34].

9. ***Assigned Claims*** - Patients receiving benefits through the Assigned Claims Facility (ACF) are limited to $250,000 of coverage. [§3172(5) - pg. 51].

10. ***Non-Residents*** - The claim of non-residents are limited to $50,000, which limitation apparently includes wage loss and replacement services and seems to apply regardless of where the accident happened or if the non-resident was a passenger in a Michigan insured vehicle. [§3107(3)(D) - pg. 35].

11. ***Payment Denials*** - Patients or providers who have had payment of benefits denied can question the insurer's denial by discussing the issue with a reviewer who *"an insurer shall designate."* [§3107(3)(G) - pg. 35, 36].*

12. ***Attorney Fee Penalties*** - Attorney fee penalties against insurers are severely limited. In attendant care disputes, *"attorney fees may only be awarded . . . for services rendered in the 12-month period immediately preceding the date the insurer is notified of the dispute."* In other words, any legal services rendered by an attorney representing a patient or provider after the insurer receives notice of the dispute are not recoverable. The Bill further states that *"evidence of the manner in which an insurer processed the claim for benefits is not admissible at trial of an action to recover benefits under this chapter."* [§3148(1)(2) - pg. 45].

13. ***Loss of Jury Trial Right*** - The Bill provides that all questions dealing with *"whether a charge is reasonable or whether a product, service, or accommodation is*

medically appropriate and medically necessary is a question of law to be decided by the court," not a jury. [§3157(4) - pg. 47].*

14. ***Illusory Premium Reductions*** - The Bill creates minimal premium savings which can be easily circumvented. The Bill requires insurers, by the end of 2013, to reduce rates by $150 from what they were on January 1, 2013. However, insurers can increase the rates one year later without limitation. [§3181(2)(3) - pg. 52].

15. ***Closing of the MCCA*** - The Bill closes the current MCCA and authorizes opening a new Catastrophic Claims Association that would reimburse insurers for losses between $530,000 and $1,000,000. In doing so, it allows the current MCCA to keep issuing annual premium assessments even though it will never have another new patient. When the last patient serviced by the current MCCA dies, all of the money that is then in the MCCA will be transmitted to the new Catastrophic Claims Association, rather than Michigan rate payers. [§3104(23) - pg. 17, 18].

16. ***Retroactivity*** - The Bill provides that virtually all of the reductions in benefits and charges contained in the Bill are retroactive to any claim that occurred prior to the passage of the new Bill. The Bill states *"payment to providers for . . . products, services and accommodations are subject to the limits in this section and §3107C and the limitations on charges in §3157."* [§3107(5) - pg. 38].

---

* Similar language and concepts were contained in Proposal C, a referendum, which was resoundingly defeated by Michigan voters in 1994.